FINALIZED SEER SINQ'S

July 2011

Question: 20110111

Status
Final

Question
MP/H Rules/Multiple primaries--Breast: Right breast DCIS diagnosed 2007, followed by bilat mastectomies with neg lymph nodes and neg margins (patient refuses tamoxifen at that time). In 2010, right chest wall mass was excised and revealed infiltrating ductal ca with neg axillary lymph nodes. Physician is stating recurrence but per breast rule M8, the invasive tumor must be a new primary. However the patient had previous mastectomy so would the primary site be coded to breast or chest wall?

Discussion

Answer
This is a recurrence, not a new primary. This second tumor would be coded as a new primary ONLY if the pathology report states that it originated in breast tissue that was still present on the chest wall. When there is no mention of breast tissue, the second tumor is a regional metastases to the chest wall (this is a recurrence of the original tumor).

In turn, this means that there was at least a focus of invasion present in the original tumor that was not identified by the pathology lab. You need to change the behavior code on the original abstract from a /2 to a /3 and change the stage from an in situ to localized.

History

Last Updated
07/21/11

Question: 20110110

Status
Final

Question
MP/H Rules/Multiple primaries--Head & Neck: How should transformations of histology be handled? See discussion.

Discussion
A neuroesthesioblastoma of nasal cavity diagnosed in 1991 with multiple recurrences of the same histology then "recurs" in 2008 in the left orbit with biopsy histology of "Sarcoma, NOS, high grade." and resection histology of "High grade fibrosarcomatous transformation of esthesioneuroblastoma." Physicians' clinical documentation continue to refer to this as recurrence. Is this a second primary because the site and histology are now different from the original tumor? Or are histologic transformations always considered recurrences of the original tumor?

Answer
Our current MP/H rules make this a new primary because it is a different histology.

The revised MP/H rules will include tables to define tumors that de-differentiate (transform) and recur with what is seemingly a different histology. Although the rules will be changed in the future, we must use the rules in place at this time for this case.

History

Last Updated
07/22/11

FINALIZED SEER SINQ'S

July 2011

Question: 20110109

Status
Final

Question
MP/H Rules/Multiple primaries--Heme & Lymphoid Neoplasms: Two separate myeloma cases. Both of these have the diagnosis of a Multiple Myeloma/Plasma Cell Myeloma, Plasmacytoma, and a Plasma Cell Leukemia. These 3 histologies were diagnosed at the same time. I've looked thru the MP Rules and Database and come up with 3 separate primaries. Am I understanding this correctly? I especially am questioning if the Plasmacytoma histology and MM/Plasma Cell Myeloma are one in the same.

Discussion

Answer
This answer assumes that the plasmacytoma is primary in bone.

This is a single primary coded to multiple myeloma/plasma cell myeloma. The steps used to determine this answer are as follows:

Step 1: Search the Hemato DB for plasmacytoma. Click on plasmacytoma of bone. Display the information and check the transformation box which shows that plasmacytoma of bone transforms to multiple myeloma. That means that plasmacytoma is a chronic neoplasm and multiple myeloma is an acute neoplasm. The chronic (plasmacytoma) and the acute (MM/PM) were dignosed within 21 days.

Step 2: Go to the MP rules. Use M7: chronic and acute phase of disease diagnosed within 21 days and there is one bone marrow biopsy. Code the acute disease, plasma cell myeloma.

Step 3: Now you need to determine whether plasma cell myeloma/multiple myeloma and plasma cell leukemia are multiple primaries. Search the Hemato DB for plasma cell leukemia. See the abstractor notes which say plasma cell leukemia is now listed as a variant of plasma cell myeloma 9732/3 rather than being a "stand-alone" neoplasm. So that means that you code only the plasma cell myeloma/multiple myeloma.

History

Last Updated
07/21/11

Question: 20110108

Status
Final

Question
Primary site--Heme & Lymphoid Neoplasms: I have a systemic mastocytosis case to report but am unsure what to use as primary site. The physician states the patient has systemic mastocytosis involving the bone marrow, spleen, lymph nodes with associated leukocytisis, mild anemia and thrombocytopenia. A bone marrow bx was done. C42.1?

Discussion

Answer
Code the primary site to bone marrow. See the Hematopoietic DB. Search on mastocytosis and display the abstractor notes which say

the bone marrow is always involved, the white and red pulp of the spleen may be involved with systemic mastocytosis. This is how your patient presents, involvement of the bone marrow is the primary site. The spleen is secondarily involved because the spleen cleanses the blood and the neoplastic cells have infiltrated the red and white pulp of the spleen. The same is true of the lymph nodes. Although the LNs are rarely involved, they may be involved when the patient has systemic mastocytosis.

Last Updated
07/21/11

Question: 20110107

Status
Final

Question
Primary site/Histology--Heme & Lymphoid Neoplasms: Which site/histology code for the following case? See discussion.

Discussion
Large mediastinal mass, cervical lymphadenopathy. (But no biopsy of either of these or statement that they are involved.)

Bone marrow biopsy - 100% cellular marrow with involvement by precursor T lymphoblastic leukemia

Peripheral Blood - Precursor-T lymphoblastic leukemia

Discharge summary and office notes - T cell acute lymphoblastic leukemia

Answer
Code the histology Adult T cell leukemia/lymphoma 9837/3 and the primary site C778 lymph nodes, multiple regions.

The following steps were used to find the answer.

Search the Hemato DB for "T-cell lymphoblastic." The matched terms display precursor T-cell lymphoblastic lymphoma, NOS 9729/3. ALWAYS check the abstractor notes. These notes tell you that the code 9729/3 is not used for cases diagnosed 2010 and later. It refers you to 9837/3. Search the Heme DB for 9837/3 and the display is Adult t-cell leukemia/lymphoma. The primary site box refers you to Module 3 PH11. The abstractor notes say this disease is characterized by peripheral blood involvement and widespread lymph node involvement. These characteristics are the reason WHO made the separate lymphoma and leukemia codes obsolete and now classifies the disease as a leukemia/lymphoma.

To determine primary site, go to module 3 PH11 as instructed in the primary site box. Let me preface the next comments with this statement - we have noted that the "warning boxes" for the lymphoma/leukemia codes do not mention both rules PH11 and PH12 as they should. This will be corrected in the next revision.

When you go to PH11 it tells you that for the lymphoma/leukemia codes, the primary site is coded to bone marrow when bone marrow is the ONLY site of involvement. That does not fit your case. Go on to PH12 which says to code the primary site to the lymph node region(s) when there is involvement of lymph nodes (there may also be involvement of bone marrow).

For lymphomas, lymph node adenopathy identified on scans is coded as positive lymph node involvement. Using that rule, you have involvement of cervical and mediastinal lymph nodes. Using Appendix C, cervical lymph nodes C770 are classified as the head and neck lymph node region and mediastinal lymph nodes C771 are in the intrathoracic lymph node region. Lymph nodes in multiple regions are coded C778 using rule PH30.

History

Last Updated
07/21/11

FINALIZED SEER SINQ'S

July 2011

Question: 20110106

Status
Final

Question
Primary site--Heme & Lymphoid Neoplasms: What is the primary site for a 2010 follicular lymphoma involving the spleen and lymph nodes above & below the diaphragm?

Discussion

Answer
There are only a few lymphomas that originate in the spleen. In most cases, the spleen is a secondary site of involvement. To determine the primary site, follow these steps.

Step 1: search the database for "follicular." Select follicular lymphoma. Click display.

Step 2: Use the Abstractor Notes. The notes say "FL predominantly involves lymph nodes. Spleen is listed as a secondary site.

Step 3: Use the Heme Manual, PH section. Go to Module 7 which is a module designed to help you code primary site for lymphomas. See PH36 Code the primary site to lymph nodes, NOS C779 when lymphoma is present in an organ and lymph nodes that are not regional for that organ.

History

Last Updated
07/21/11

Question: 20110105

Status
Final

Question
Multiple primaries--Heme & Lymphoid Neoplasms: Pathology report on a bone marrow states:

"Lymphoproliferative disorder, small cell lymphocytic lymphoma/small cell lymphocytic leukemia consistent with marginal zone lymphoma. Would this be one primary or two due to the "consistent with"?

Discussion

Answer
Our Hematopoietic/Lymphoid neoplasm physician expert replied as follows: Abstract one primary (MZL). The pathologist is using "small lymphocytic lymphoma" in a descriptive manner (MZL is comprised of small lymphocytes) rather than in a "diagnostic" manner.

History

Last Updated
07/21/11

FINALIZED SEER SINQ'S

July 2011

Question: 20110104

Status
Final

Question
Primary site--Heme & Lymphoid Neoplasms: Is the site code for adult T-cell leukemia/lymphoma (9827/3/5) always C42.1? Or does a positive bone marrow biopsy but with involvement documented in lymph nodes and lungs make it a C77 site?

Discussion

Answer
Code the primary site to the involved lymph nodes. See the Hematopoietic DB, Primary Site information for 9827/3. The primary site is always coded to lymph nodes (C770-C779). The Abstractor Notes state that this is a systemic disease and that extranodal sites (including lung) are often involved.

History

Last Updated
07/21/11

Question: 20110103

Status
Final

Question
MP/H Rules/Histology/Ambiguous terminology: Can the word "variety" be used in coding histology? The list of terms to denote a more specific histology does not include "variety" and in all of the Breeze training sessions, emphasis was placed on that list being the only words we could use. However, I am being told in an audit that "variety" is synonymous with "type," so we should use it. Are we to use synonyms or just the list as it is strictly written?

Discussion

Answer
Variety is not one of the words used in the MP/H rules to designate a more specific histology.

History

Last Updated
07/21/11

FINALIZED SEER SINQ'S

July 2011

Question: 20110102

Status
Final

Question
Reportability--Heme & Lymphoid Neoplasms: Is idiopathic thrombocytopenia reportable on 2010 cases? If so, what morphology code would you use? Is autoimmune thrombocytopenia reportable on 2010 cases? If so, what morphology code would you use?

Answer
Thrombocytopenia is not a neoplasm so it is not reportable. Thrombocytopenia and thrombocythemia are not synonyms. Cytopenia and cythemia have different definitions.

Last Updated
07/21/11

Question: 20110101

Status
Final

Question
Primary site--Heme & Lymphoid Neoplasms: A diffuse large B cell lymphoma with abdominal lymph node,neck lymph node, and spleen involvement. What is the correct site code for this case? C778 or C779?

Discussion

Answer
Use Rule PH30 and code to lymph nodes of multiple regions C778. The spleen is a primary site for only a few lymphomas (noted in the Hemato DB). Since the spleen filters blood, it is often reactive (splenomegaly) or frankly involved with the lymphoma. That reaction or involvement, however, does not affect the primary site coding, only the involved nodes are used in coding primary site.

History

Last Updated
07/21/11

Question: 20110099

Status
Final

Question
Primary site--Heme & Lymphoid Neoplasms: Is bilateral pelvic lymph node involvement of SLL 1 or 2 lymph node regions? Am I correct in thinking that bilateral disease would count as 2 lymph node regions?

Discussion

Answer
The right and left pelvic nodes are two regions. See Appendix C Lymph Node/Lymph Node Chain Reference Table in the Hemato Manual. Lymph node regions with "right and left" are two regions.

Last Updated
07/21/11

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Question: 20110098

Status
Final

Question
Multiple primaries--Heme & Lymphoid Neoplasms: Are a granulocytic sarcoma (9930) and a juvenile myelomonocytic leukemia (9946) diagnosed at the same time a single or multiple primary? Which M rule would apply?

Answer
This is a single primary. The granulocytic sarcoma is a solid manifestation of myeloid cells and is secondary to the myelomonocytic leukemia. When a sarcoma of myeloid cell origin occurs simultaneously with a leukemia of myeloid lineage (AMML, AML, etc.) the sarcoma is a secondary manifestation of the leukemia. Currently, there are no M rules that reinforce this scenario. They will be added to the Heme Manual in the next revision.

Last Updated
07/21/11

Question: 20110097

Status
Final

Question
MP/H Rules/Histology--Breast: In reporting the histology of a breast carcinoma what significance does neuroendocrine differentiation have in coding of histology? See discussion.

Discussion
i.e. ductal carcinoma with neuroendocrine differentiation/features 8500 or 8246

i.e. insitu breast carcinoma with spindle cell pattern and neuroendocrine differentiation? 8500, 8010, 8523, or 8246?

Answer
Apply the MP/H rules to each individual case.

Rule H17 applies to the first example. Neuroendocrine is not a specific duct carcinoma. Rule H12 does not apply.

For the second example, Rule H6 is the appropriate rule, but the wording of the rule is incomplete. It is intended to allow you to use code 8523/2 when there is a combination of intraduct and other in situ carcinomas. We will correct this in the revised MP/H rules.

Note that while neuroendocrine differentiation can be identified, it seems to have no prognostic implications.

History

Last Updated
07/22/11

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July 2011

Question: 20110096

Status
Final

Question
Behavior--Lung: Is a lobectomy specimen with a stated diagnosis of adenocarcinoma coded with an in situ behavior if that diagnosis is further classified in the CAP protocol layout as having the HISTOLOGIC TYPE of "non-mucinous bronchiolo-alveolar carcinoma (adenocarcinoma in situ)" when the pathologist also classifies the case as a pT1b, pN0 tumor? See discussion.

Discussion
Is the following case coded with an invasive or in situ behavior when a RUL lobectomy specimen reveals adenocarcinoma and the Histologic Type per the CAP protocol layout is non-mucinous bronchiolo-alveolar carcinoma (adenocarcinoma in situ)? The stage per the pathologist is pT1b, pN0. Per the COMMENT section in the pathology report, "The terminology adenocarcinoma in situ is based on a recent publication in the Journal of Thoracic Oncology (Volume 6, #2, February 2011). Based on this criteria, this represents adenocarcinoma in situ with no evident invasive component."

Answer
Code the behavior as in situ. The pathologist has the final say on the behavior of the tumor. This pathologist is indicating that in his opinion based on a recent publication, this tumor is in situ.

History

Last Updated
07/26/11

Question: 20110085

Status
Final

Question
Multiple primaries--Heme & Lymphoid Neoplasms: Should this be coded as two primaries? If so, would this be based on perhaps Rule M8 or Rule M13? See discussion.

Discussion
Path report for bone marrow biopsy reads EXACTLY as follows:

"Bone marrow, left iliac crest (aspirate, clot section, and biopsy):

- Acute myeloid leukemia.

- Chronic lymphocytic leukemia.

Comment:

The patient is a 80 year old man without any significant past medical history who presents with pancytopenia. The bone marrow shows acute myeloid leukemia, most consistent with acute myeloid leukemia with maturation (of the total cells are blasts). There is also a small population (the total cells) of lambda clonal B-cells consistent with chronic lymphocytic leukemia. MDS related AML after treatment and synchronous diagnosis of AML and CLL have both been reported in the literature and the relationship of the two lesions in this case is unclear."

Rule M7 says one primary if there is one bx, but in this case, both AML and CLL are being confined in the same bx and no other bx was

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performed.

Answer
Code as two primaries. The CLL is a lymphoid neoplasm and the AML is a myeloid neoplasm. This is not a "transformation" or progression of disease. Use M13, go to the Heme DB and use the Multiple Primaries Calculator. The calculator will confirm that these two neoplasms are separate/multiple primaries.

History

Last Updated
07/01/11

Question: 20110080

Status
Final

Question
Grade--Renal pelvis: How should grade be coded for a non-invasive high grade papillary urothelial carcinoma of the renal pelvis? See discussion.

Discussion
Per instructions in SPCSM 2010, Appendix C, Coding Guidelines for Bladder, "Code grade 9 (unknown) for non-invasive urothelial (transitional) tumors." The Coding Guidelines listed under Renal Pelvis, Ureter are only for Kidney (C649). Do the grade instructions under Bladder apply to ALL non-invasive urothelial tumors, or are we to use the Kidney grading instructions to code grade for renal pelvis and ureter malignancies?

Answer
Assign grade code 4. Follow the instructions in the main part of the 2010 SEER manual under the data item Grade (pages 73 - 76). There are no specific instructions for coding grade for renal pelvis. Apply the general instructions in the absence of site-specific instructions. **Last Updated**06/17/11

Question: 20110068

Status
Final

Question
MP/H Rules/Multiple primaries--Bladder: How many primaries are in this scenario and which MP rule did you use? See discussion.

Discussion
A patient has papillary transitional cell carcinoma of the bladder in March of 2009. Then in June of 2010, patient has another TURBT that shows flat in situ and invasive high grade urothelial carcinoma with ADDENDUM: Genzyme IHC show results consistent with high grade invasive urothelial carcinoma with neuroendocrine features. Two months later a liver biopsy shows poorly differentiated malignant tumor with ADDENDUM: Genzyme IHC results show metastatic poorly diff. carcinoma with neuroendocrine features, favor bladder primary. Is this Seq. 2 of the bladder with histology code 8246/3? Neuroendocrine is not listed as a urothelial tumor in Table 1 of MP/H.

Answer
This is a single primary according to M6. The 2010 diagnosis is urothelial carcinoma. Neuroendocrine features do not change the histologic category.

Last Updated
06/17/11

FINALIZED SEER SINQ'S

July 2011

Question: 20091114

Status
Final

Question
MP/H Rules/Multiple primaries--Breast: Would a left chest wall mass excision stated to be ductal carcinoma consistent with a breast primary and, "compatible with either local recurrence or potentially a metastasis" be a new primary per the MP/H rules? See discussion.

Discussion
Patient underwent mastectomy in 1986 for infiltrating ductal carcinoma of left breast. Excision of left chest wall mass in March 2009 showed ductal carcinoma consistent with breast primary. The pathology report COMMENT stated it would be compatible with either local recurrence or a metastasis. The patient's primary breast carcinoma material is not available for direct comparison and the MP/H rules instruct us to ignore metastasis.

Answer
For cases diagnosed 2007 – 2011, the MP/H rules do not apply to metastasis. If there is no further information available for this case, the MP/H rules do not apply to the 2009 diagnosis.

History

Last Updated
07/26/11

Question: 20071107

Status
Final

Question
MP/H Rules/Recurrence--Breast: If the pathologist and oncologist call a 2007 lobular carcinoma that appears in a skin nodule of a mastectomy scar a recurrence of a patient's 1975 primary breast duct carcinoma, should we abstract this as a new primary?

Discussion
According to the pathologist and oncologist, the change in histology is attributed to the present availability of E-cadherin, which was not available in 1975.

Answer
For cases diagnosed 2007-2011, abstract the 2007 diagnosis as a separate primary using rule M5.

Rule M5 applies to this case because it comes before rule M12. Furthermore, based on your statement, the answer presumes that the original tumor was duct carcinoma only, there was no lobular carcinoma present. This must be a new primary because there are two different histologies.

The 2007 MP/H rules were developed with input from clinicians. They advised that a subsequent breast tumor more than five years later is a new primary. It is important to apply the rules so that these cases are handled in a consistant manner across all registries.

History

Last Updated
07/26/11